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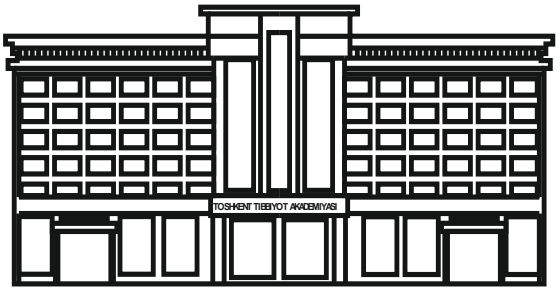
TOSHKENT TIBBIYOT AKADEMIYASI AXBOROTNOMASI



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RESULTS OF TREATMENT OF SICK CHILDREN WITH RELAPSE AND CONTINUED GROWTH OF SUPRATENTORIAL BRAIN GLIOMAS

Ashrapov J.R., Asadullaev U.M., Kazakov Sh.J.

РЕЗУЛЬТАТЫ ЛЕЧЕНИЯ БОЛЬНЫХ ДЕТЕЙ С РЕЦИДИВОМ И ПРОДОЛЖЕННЫМ РОСТОМ СУПРАТЕНТООРИАЛЬНЫХ ОПУХОЛЕЙ ГОЛОВНОГО МОЗГА

Ашрапов Ж.Р., Асадуллаев У.М., Казаков Ш.Ж.

SUPRATENTOORIAL MIYA O'SMALARINING TAKRORLANISHI VA O'SISHI DAVOM ETADIGAN KASAL BOLALARNI DAVOLASH NATIJALARI

Ashrapov J.R., Asadullaev U.M., Kazakov Sh.J.

Republican specialized scientific and practical medical center neurosurgery

Цель: *изучение результатов лечения больных детей с рецидивом и продолженным ростом опухолей головного мозга.* ***Материал и методы:*** *работа выполнена в отделении нейрохирургии детского возраста Республиканского специализированного научно-практического медицинского центра нейрохирургии. Под наблюдением были 102 оперированных ребенка с глиальными опухолями головного мозга.* ***Результаты:*** *результаты лечения продолженного роста и рецидива глиальных опухолей у детей зависят от объема удаленных опухолей, степени анаплазии, гистоструктуры и возраста ребенка.* ***Выводы:*** *комплексное лечение позволяет улучшить качество жизни больных детей с глиальными опухолями головного мозга.*

Ключевые слова: *опухоли головного мозга, комплексное лечение, детский возраст.*

Maqsad: *miya o'smalarining qaytalanishi va o'sishi davom etadigan kasal bolalarni davolash natijalarini o'rganish.* ***Material va usullar:*** *ish Respublika ixtisoslashtirilgan neyroxirurgiya ilmiy-amaliy tibbiyot markazining bolalar neyroxirurgiyasi bo'limida bajarildi. Miyaning glial o'smalari bilan operatsiya qilingan 102 nafar bola kuzatuv ostida bo'ldi.* ***Natijalar:*** *bolalarda glial o'smalarning davom etishi va qaytalanishini davolash natijalari olib tashlangan o'smalar hajmiga, anaplaziya darajasiga, gistostrukturaga va bolaning yoshiga bog'liq.* ***Xulosa:*** *kompleks davolash glial miya shishi bo'lgan kasal bolalarning hayot sifatini yaxshilaydi.*

Kalit so'zlar: *miya shishi, kompleks davolash, bolalar yoshi.*

At present, the problem of treating glial brain tumors is one of the most significant tasks of modern neurosurgery. A comprehensive approach to the treatment of glial brain tumors is generally recognized, including surgery, radiation therapy, and antiblastic chemotherapy [2,3,8,17].

The general principle of treatment of patients with glial brain tumors is complexity. Complex active treatment includes surgery, radiation therapy, chemotherapy, immunocorrective therapy and specific antitumor immunotherapy being developed in some clinics [4,12,18]. The main tasks of brain glioma surgery are: histological verification of the diagnosis, reduction of neurological deficit, brain decompression, and tumor volume reduction [1].

It is known that continued growth is not uncommon for both benign and malignant brain tumors, which can develop several years after the treatment of the primary tumor. So, for example, for ependymal tumors, the early appearance of continued growth is considered to be up to 8.8 months, and the late one is more than 8.8 months [15,20].

Indications for reoperation for the continued growth of hemispheric tumors are clinical manifestation of hypertensive syndrome with a tendency to progression, the appearance and aggravation of focal neurological deficit, a picture of tumor progression on CT and MRI in the form of a mass effect, displacement of structures along the midline, a sign of decay and hemorrhage into the tumor. The lack of effect of conservative therapy is also an indication for surgical intervention [10].

Until now, there is no common point of view on the concept of "continued growth" and "recurrence" of brain tumors. The length of resection and tumor localization are the main prognostic factors. However, the data of neuroimaging studies are much more informative in determining the degree of tumor removal [11]. N.K. Rollins believes there is a tendency for surgeons to exaggerate the extent of their resection. Cases of recurrence of the disease after total removal of the tumor should be denoted by the term "relapse", and after incomplete removal - "continued growth". It is noted in the literature that if the protocols of the operation determined incomplete removal of the tumor, then in all cases, CT or MRI revealed the remainder of the neoplasm, while total removal was not always confirmed by CT or MRI of the brain [17,19,21].

According to the authors, in the group with clinical detection, the duration of continued growth was significantly shorter than with radiographic. When identifying early and late terms of the onset of continued tumor growth, most of the early terms were established clinically; even after distribution by nosology, this difference persisted, and age, gender and race were not statistically significant. In the group with radiographic detection of continued growth, patients with a large volume of surgical intervention prevailed [20].

According to M. Ebato et al. (2002), a 9-year-old girl with xanthoastrocytoma in the renoptemporal region underwent total tumor resection. 14 months after surgery, he developed headaches in the morning. MRI

data revealed local continued tumor growth in the right Sylvian sulcus. Continued tumor growth accompanied by perifocal edema was re-detected 2 months after repeated total resection on MRI. The prescribed radiation therapy made it possible to achieve remission [16].

The indications for surgery with continued growth of gliomas are the same as for the first surgery. Life expectancy during reoperations increases in most patients, especially with a significant mass effect of the tumor. An improvement in the quality of life (according to the Karnofsky scale up to 60 points and higher) is noted in 52–67% of patients with anaplastic astrocytomas [5].

The increase in survival time after reoperation allows additional time for adjuvant treatments (radiation and chemotherapy), and shrinking the tumor increases the chances of their effectiveness. Reoperation is indicated when at least 6 months have passed after the first operation and the patient has a high (at least 60 points) Karnofsky index [6,7].

Hemispheric tumors and their continued growth remain a problem that attracts the attention of researchers in various fields of medicine. Despite the possibilities of neuroimaging techniques, neurosurgical tactics, radiation and chemotherapy, the solution to the problem of the onset of continued tumor growth remains unsatisfactory. Factors such as the early age of patients and the histological type of tumor cannot be modified and are associated with a poor prognosis for the patient [13,14]. Using the tactics of the greatest possible amount of resection may affect the outcome of treatment. However, local continued growth is the most frequent complication, which is controlled by complex treatment [9].

The volume of the remote up

Purpose of the study

To study the results of treatment of patients with relapse and continued growth of supratentorial glial brain tumors, depending on the volume of the removed tumor, the degree of anaplasia, the age of the child and the complex treatment performed.

Material and methods

Scientific work was carried out in the Department of Pediatric Neurosurgery of the Republican Specialized Scientific and Practical Medical Center for Neurosurgery of the Ministry of Health of the Republic of Uzbekistan. The study was based on 102 operated children with glial brain tumors.

Patients underwent somatoneurological examination, and were supplemented with a number of instrumental research methods, such as: computed tomography of the brain, ultrasound of internal organs, EEG, MRI of the brain. All patients underwent surgery with removal of tumors of various sizes, followed by radiation therapy, and, if necessary, chemotherapy. A verified histological diagnosis has been established for each child.

Results and discussion

Clinical signs of continued tumor growth were renewed intracranial hypertension (60%) or increased manifestations of epileptic syndrome (25%), as well as focal neurological deficits (15%) indicate continued tumor growth.

Further, continued tumor growth was confirmed by additional research methods (CT or MRI of the brain)

One of the risk factors for the appearance of continued growth of brain tumors in children is the radicality of the operation (total - in 41.8% of cases), the degree of malignancy of the neoplasm (56.3% of the anaplastic ones), tumor localization, its location in the medial hemisphere and spread to neighboring lobes and subcortical formations (27.2%). The totality of removal was calculated by the program "Calculate the volume of neoplasm".

Children with brain tumors operated on for the underlying disease were divided into two groups. The first group included patients who showed continued tumor growth, the second - patients who did not have it during the entire observation period.

Table 1

Dependence of continued tumor growth on the degree of radicality of the surgical intervention, abs. (%)

Power radicalism operations	Frontal lobe	Temporal lobe	Parietal lobe	Medial structures	Brain stem	Occipital lobe	Inall, bs.
Total	4 (44,4)	2 (16,7)	1 (10)	2 (15,3)	-	2 (22,2)	11
Subtotal	1 (11,1)	4 (33,3)	4 (40)	6 (46,1)	-	6 (66,7)	21
Partial and biopsy	4 (44,4)	6 (50)	5 (50)	5 (38,4)	2 (100)	1 (11,1)	23
In total	9 (100)	12 (100)	10 (100)	13 (100)	2 (100)	9 (100)	55

From Table 1, it is seen that children who subsequently had continued growth of the neoplasm (55 patients), mainly performed partial resection (41.8) and subtotal resection (38.2%). A large proportion of subtotal resection accounted for tumors localized medially 46.7% ($p \leq 0.05$). Tumors in 23 (41.8%) patients were attributed to histologically benign variants, in 32 (58.1%) - to anaplastic ones (Table 2). Anaplastic neoplasm was more characteristic of the location of the tumor in the medial structures.

According to CT and MRI data of the brain, signs of continued growth are the renewal of the tumor focus or increase in size, depending on the radicality of the operation. The presence of perifocal edema of mixing of the median structures indicates the progression of tumor growth.

Table 2

Distribution of tumors by degree of anaplasia depending on localization, abs. (%)

Histological type	Frontal lobe	Temporal lobe	Parietal lobe	Medial structures	Occipitallobe	Inall, Abs.
Benign	4 (44,4)	5 (41,7)	4 (40)	6 (40)	4 (44,4)	23
Anaplastic	5 (55,6)	7 (58,3)	6 (60)	9 (60)	5 (55,6)	32
In total	9 (100)	12 (100)	10 (100)	15 (100)	9 (100)	55

According to CT data, the average tumor size was 4.5±1.5 cm, the tumor focus had clear boundaries - in 13 (52%) patients, indistinct - in 12 (48%) patients. The X-ray density (HU) changed with continued growth. Hypodense foci - in 11 (44%) patients with typical gliomas, in 6 (24%) patients with anaplastic gliomas. Hyperdense foci - in 5 (20%) patients with malignant gliomas. Isodense foci were also found in 3 (12%) cases and in malignant gliomas. Continued growth of gliomas containing cysts was noted in 12 cases. The accumulation of contrast agents with continued growth of gliomas increased in comparison with the primary images.

According to MRI data of the brain with continued growth, the average diameter was 5.5±1.0 cm, heterogeneous. With continued growth, isodense foci were found - in 13 (43.3%) patients, which was more typical for low-grade gliomas, with anaplastic forms of continued growth of gliomas - in 17 (56.7%) patients, hypodense foci were noted. Continued growth of a tumor with a solid-cystic component was noted in 14 cases.

The predominantly malignant histological nature of the neoplasms (Figure), despite a shorter delay in the operation after the correct diagnosis was established, led to large tumors, predominantly invading adjacent brain structures. In 27 (49%) of 55 cases, reoperations were performed with removal of continued tumor growth, while in 9 (33.3%) patients I and II degrees of anaplasia were established and in 18 (66.7%) - III-IV degrees of anaplasia ... In patients without continued growth there wer47 patients, of which 34 (72.3%) had I and II degrees of anaplasia and 13 (27.6%) had III-IV degrees of anaplasia.

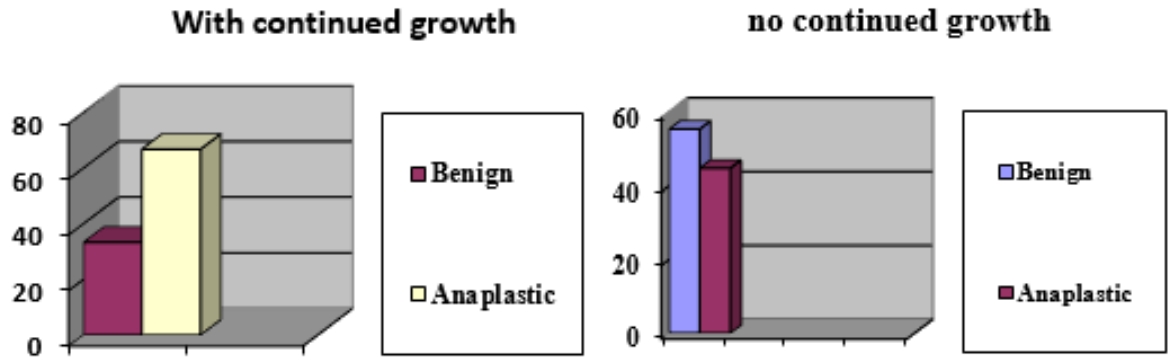

Figure. Histological structure of tumors and their continued growth.

When choosing surgical tactics for patients with continued growth of cerebral gliomas, it should be based on data concerning the histological type of tumor, features of tumor spread and involvement of neighboring brain structures in the process, from the nature of growth, infiltrative growth was noted in 26 observations, nodal growth in 29 observations, tumor vascularization, presence hemorrhages were detected - in 14 patients, which indicates increased vascularization and the time between the primary removal of the tumor and continued growth, as well as determined by the clinical picture.

Continued growth of tumors in the studied group of patients with gliomas was observed in 55 (53.9%) cases out of 102. It was determined 1 month after the first operation, the maximum late period was 2 years±6 months. On average, the appearance of the first signs of continued neoplasm growth was 5 months. The duration of the disease between the first and second surgery for recurrent tumors ranged from 1.5 to 2 years,

Histologically, in the group of children with continued growth of a frontal lobe tumor, astrocytomas (11), including pilocytic (4), fibrillar (5), fibrillar-protoplasmic (8), anaplastic (11), glioblastoma (10), anaplastic oligoependymoma (1), anaplastic ependymoma (3), anaplastic ganglioglioma (2).

Dependence of continued tumor growth on the degree of radicality surgical resection is presented in Table 3., children in whom the continued growth of the neoplasm was further revealed (55 patients), mainly underwent subtotal resection (58.3%), as well as partial removal and biopsy (82.1%) of the tumor.

We analyzed the continued growth of a brain tumor in three age groups of children, in which there were significant differences between the groups in Table 4.

Table 3

Dependence of continued tumor growth on the degree of radicality surgical resection, abs. (%)

	Total	Subtotal	Partial and biopsy	Inall, abs.
With continued growth	11 (28,9)	21 (58,3)	23 (82,1)	55
With out continued growth	27 (71,1)	15 (41,7)	5 (17,9)	47
In total	38 (100)	36 (100)	28 (100)	102

Table 4

Distribution of patients with continued growth and without it depending on age, abs. (%)

Age	With continued growth, n=55	With outcontinued growth, n=47	Inall, abs.
Up to 1 of the year	13 (23,6)	2 (4,2)	15 (14,7)
From1to7 year	31 (56,3)	17 (36,2)	48 (47,1)
>8 year	11 (20)	28 (59,6)	39 (38,2)
In total	55 (100)	47 (100)	102 (100)

The dependence of continued tumor growth on the age of patients with brain tumors is presented in table 4., we see that a large number of children with continued growth accounted for the age group of children from 1 to 7 years old, which was 56.3%, while the group of patients without continued growth was noted in the age group> 8 years old, which was 59.6% (p≤0.05).

In 47 of 55 observations of continued growth, the latter was initially determined clinically and was further confirmed by additional research methods (CT or MRI of the brain). In one case, intracranial metastasis was noted (10%), in the remaining nine cases (90%), continued tumor growth was exclusively in the operation area.

To identify the early clinical manifestations of continued growth, we examined the first signs of a tumor that took place before the operation and compared them with the symptoms observed in the postoperative period. The progression of the disease in (60.0%) was indicated by the return or increase of hypertensive syndrome, (15.0%) - the increase in focal neurological symptoms followed (within several days) by the return of congestion in the fundus in one of them. In 8 patients (14.5%), continued tumor growth was detected during control CT scan of the brain 3 months after surgery.

The absence of hypertensive syndrome, the absence of stagnant changes in the fundus, the absence of deterioration of focal neurological symptoms spoke against the continued growth of the tumor.

Children with continued growth, operated on for the underlying disease, were divided into two groups depending on the combined treatment after surgery. The first group included patients who showed continued tumor growth, the second - patients who did not have it during the entire observation period.

The duration of the disease from the first manifestations to surgery in the group of children with continued growth was significantly shorter than in the second group without continued growth and was 1.5 years ± 2 weeks. This fact is explained by the predominance of malignant histological variants of neoplasms in the group of patients with continued growth. This circumstance can also partly explain the predominant onset of the disease in the group with continued growth from general cerebral and hypertensive syndrome, since in children without continued tumor growth as the first manifestation of the disease, epileptic and general cerebral and hypertensive symptoms prevailed in equal measure.

The dependence of continued tumor growth on the degree of radicality of surgical resection is presented in table 5. Subtotal resection was predominantly performed in patients who subsequently showed continued neoplasm growth in the main group and in the control group.

Table 5

Distribution of patients into groups with continued growth and without tumors with total resection, abs. (%)

The degree of radicalism operations	Maingroup	Controlgroup	In all
With continued growth	4 (13,8)	7 (77,8)	11 (28,9)
With outcontinued growth	25 (86,2)	2 (22,2)	27 (71,1)
In total	29 (100)	9 (100)	38 (100)

From Table 5, it can be seen in patients with total removal of the absence of continued growth in the main group - in 25 (86.2%) patients p≤0.05, while continued growth in the control group was noted - 7 (77.8%) patients out of 9 patients.

With a subtotal removal of the absence of continued growth, 41.7% of observations were noted, continued growth was 58.3% of 36 children. In the main group - in 14 (67%) patients, p≤0.05 out of 21, while continued growth in the control group was noted - in 14 (93.3%) patients out of 15 patients (Table 6).

Table 6

Distribution of patients into groups with continued tumor growth after subtotal resection, abs. (%)

The degree of radicalism operations	Maing roup	Control group	In all
With continued growth	7 (33)	14 (93,3)	21 (58,3)
With outcontinue dgrowth	14 67)	1 (6,7)	15 (41,7)
In total	21 (100)	15 (100)	36 (100)

With partial resection of the tumor presented in Table 7, the absence of continued growth was noted in 17.9% of cases, continued growth was 82.1% (p≤0.05) out of 28 children. In the main group - in 5 (33.3%) patients p≤0.05 out of 15, continued tumor growth was absent, this is due to the providence of chemotherapy - radiation therapy, which keeps the tumor growth, while continued growth in the control group was noted (100%) out of 13 patients (Table 7).

Table 7

Distribution of patients into groups with continued tumor growth with partial resection, abs. (%)

The degree of radicalism operations	Maing roup	Control group	In all
With continued growth	10 (66,7)	13 (100)	23 (82,1)
With outcontinue dgrowth	5 (33,3)	-	5 (17,9)
In total	15 (100)	13 (100)	28 (100)

Table 8

Comparative characteristics of treatment results in patients of two groups, depending on the appearance of continued tumor growth, abs. (%)

Treatment results	Maing roup	Control group	In all, abs.
Withcontinuedgrowth	21 (32,3)	34 91,9)	55
Withoutcontinuedgrowth	44 (67,7)	3 (8,1)	47
In total	65 (100)	37 (100)	102

As can be seen from Table 8, when comparing the results of patients in the two control and main groups without continued growth, 67.7% (p≤0.05) observations were noted in the group of patients who underwent complex treatment in the postoperative period, while continued growth was observed in 91.9% (p≤0.05) of 37 children who underwent only surgical tumor resection. This is explained by the fact that in the main group of patients after surgery, chemotherapy and radiation therapy were carried out later.

Conclusion

Analysis of our data shows that most often the relapse or continued growth of the tumor depends on the radical nature of surgical treatment, the more radically the tumor is removed, the less relapse and continued growth, also depending on the degree of malignancy of the neoplasm.

It was found that relapse and continued growth of the tumor occurs depending on the age of the patients: the vast majority of children with relapse and continued growth of the tumor are in the age groups of children under 1 year, and at the age of more than 8 years, relapse or continued growth were noted to a lesser extent.

Thus, the choice of surgical tactics in patients with continued growth of supratentorial gliomas of the brain should be based on data concerning the histological type of the tumor, the features of the tumor spread and the involvement of neighboring brain structures in the process, as well as the nature of the growth of the neoplasm.

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RESULTS OF TREATMENT OF SICK CHILDREN WITH RECURRENCE AND CONTINUED GROWTH OF SUPRATENTOORIAL BRAIN TUMORS

Ashrapov Zh.R., Asadullaev U.M., Kazakov Sh.Zh.

Objective: *To study the results of treatment of sick children with relapse and continued growth of brain tumors.* ***Material and methods:*** *The work was performed in the Department of Pediatric Neurosurgery of the Republican Specialized Scientific and Practical Medical Center for Neurosurgery. 102 operated children with glial tumors of the brain were under observation.* ***Results:*** *The results of treatment of continued growth and recurrence of glial tumors in children depend on the volume of tumors removed, the degree of anaplasia, histostructure and age of the child.* ***Conclusions:*** *Complex treatment improves the quality of life of sick children with glial brain tumors.*

Key words: *brain tumors, complex treatment, children's age.*